in medical schools nationwide. Obviously, over this period and earlier, our department has been well served by nationally and internationally recognized basic scientists.

I do not intend or attempt to refute the assumptions of the owners of the digits from which the thumbnails were extracted, but, as we all have experienced in attempting to reduce the unnecessary and unwarranted harm inflicted by ill-manicured nails of infants or headstrong pets, the process often entails excessive and useless loss of energy. Useless energy expenditure notwithstanding, the data I present are correct and can be substantiated by the public record. I would have expected an august publication such as *CMAJ* to assess the veracity of the spoken word before it was immortalized in print.

N.M. McDuffie
Professor and head
Department of Physiology
College of Medicine
University of Saskatchewan
Saskatoon, Sask.

[Dr. T. Alexander McPherson, president of the Canadian Medical Association, replies:]

The special report, with comments by Douglas Waugh, past executive director of the Association of Canadian Medical Colleges (ACMC), should be required reading for all interested in medicine and medical education in Canada.

The report contains information of interest to us all. For instance, might not an applicant to medical school find the information about who stands the best chance of getting into a Canadian medical school useful? Do you not agree with Martin Hollenberg, dean of medicine at the University of Western Ontario, that students are not being sufficiently exposed to health care planning? I know that our provincial health ministers would. Did you know that the estimated cost for producing a medical doctor in Canada is probably as high as $100 000, and don't you agree, as J. Donald Hatcher, dean of medicine at Dalhousie University, suggests in the report, that the different costs in different provinces are probably due to underfunding of some medical schools as compared with others? Will residents, interns and deans of postgraduate training not be interested to find out what some of our schools do to provide counselling on postgraduate training, career choices and licensing requirements? Surely all of us, including ministers of health, are interested in the study of medical manpower mobility done by the ACMC and the estimate that nearly one in five graduates from English-Canadian medical schools will have left Canada to practise elsewhere — mainly in the United States — by about 15 years following graduation. Finally, is the registry of organizations involved in medical education from the undergraduate through to the postgraduate level not helpful? And is the fact that the Canadian Federation of Medical Students has no address, only a telephone number, telling us something about the future?

As for the "thumbnail sketches" of our 16 medical schools, they are just that — distillations of comment from some of the most senior and knowledgeable academics in this country as recorded and reported by Charlotte Gray. They are not, and do not purport to be, the equivalent of the CACMS–LCME accreditation. They are, however, a view from the "inner outside" of our schools. Perhaps, rather than express outraged indignation, we should reflect on the criticisms and consider solutions to the problems noted — if, indeed, they exist.

I say Well done, Charlotte Gray. In my opinion her kind of commentary, and that of Dr. Waugh, is part of the reason *CMAJ* fares very well in comparative readership studies and last year was cited in the international medical literature more than 3000 times.

T. Alexander McPherson, MD
President
Canadian Medical Association

Adverse effects of NSAIDs on renal function

Linton's timely and important paper on the adverse effects of nonsteroidal anti-inflammatory drugs (NSAIDs) on renal function (*Can Med Assoc J* 1984; 131: 189–191) prompts me to report the following case, which suggests an additional renal problem related to NSAID use.

Case report

The patient, a married woman, was born in eastern Europe in 1923 and came to Canada as a young woman. Most readers are aware that tuberculosis was very common in parts of Europe until the end of World War II, and a high percentage of the population were considered to have had primary infection.

In May 1971 the patient was investigated for recurrent urinary tract infection, and intravenous pyelography showed two calcified cysts in the left kidney due to some deformity of the calices. There appeared to be some mottled calcification centrally within one of the cysts. An opacity in the right side of the abdomen had the appearance of a calcified lymph node. There had been no change in the spine since the previous examinations, in 1967 and 1968. In a patient of this age and ethnic background such findings are likely indicative of old, healed tuberculosis.

According to the records of her family physician the patient first received phenylbutazone in 1958 for back pain. The medication prescribed was Buffazone, a buffered preparation containing 100 mg of phenylbutazone. The drug was again prescribed in 1965, 1967 and 1972 and on two occasions in 1973. While the records do not reveal in all cases the dosage or duration of administration, on a number of occasions the dosage was one tablet four times a day for 30 days.

In May 1975 the patient presented with frequency, urgency, burning and recurrent cystitis. She was again seen in September and October of the same year complaining of urinary symptoms and hematuria, and finally in December of that year a diagnosis of genitourinary tuberculosis and a nonfunctioning left kidney was established. Acid-fast bacilli were cultured from the urine. A decision to perform a left nephrectomy was later reversed, and following lengthy treatment the patient eventually recovered.

Comments

In light of evidence presented previously of an association between the use of NSAIDs and the reactivation of pulmonary tuberculosis,[1] this case provides reason to suspect that reactivation of renal tuberculosis should now be considered a probable adverse effect of this group of drugs.

Michael Brennan, MD, CCFP, FCFP
Family Medical Centre
Victoria Hospital
London, Ont.

Reference

1. Tomasson HO, Brennan M, Bass MJ: Tuberculosis and nonsteroidal anti-inflammatory drugs. *Can Med Assoc J* 1984; 130: 275–278

Manitoba Medical Association's stand on binding arbitration

The newsbrief on Manitoba in the Sept. 1, 1984 issue of *CMAJ* (131: 465) is fraught with factual inaccuracies with which I must take issue.

Manitoba Health Minister Laurent Desjardins did, in fact, tell the Manitoba Medical Association (MMA) he was going to ban extra-billing but said it would not be immediately. (He has since indicated he will ban it within the next year.) Our February referendum, asking members if they would *exchange* extra-billing for a fair and reasonable form of binding arbitration, was done not "just in case" extra-billing was banned but because it was clear that extra-billing would be banned, and the association required a mechanism for resolving fee disputes in its place.

The referendum did have a 75% response rate, but 75% of those voting said they favoured obtaining binding arbitration *in exchange for the banning of extra-billing.* The question on the referendum made it clear that the two items were linked and that extra-billing (not opting-out) would be given up only if fair and reasonable binding arbitration were offered in its place.

There is no doubt that this mandate is as clear today as it was when the responses were compiled in Feb-